Fletcher, Heald & Hildreth

1300 NORTH 17th STREET, 11th FLOOR
ARLINGTON, VIRGINIA 22209

OFFICE: (703) 812-0400
FAX: (703) 812-0486
www.fhhlaw.com
www.commlawblog.com

JEFFREY A. MITCHELL
703-812-0450
MITCHELL@FHHLAW.COM

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VIA ELECTRONIC MAIL

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Re: Universal Service Contribution Methodology, WC Docket No. 06-122

To Whom It Concerns:

CommonSpirit Health (CSH), by its attorneys, writes to express qualified support for one element of the Commission's notice of proposed rulemaking in WC Docket No. 06-122.[1] First CSH, like many commenters, opposes an overall cap on the universal service programs. While universal service programs must be fiscally responsible, appropriate funding levels for each program should be set based on whether each program is meeting the objectives established for it by Congress.[2] Indeed, an overall cap would be arbitrary and would undermine the universal service principles of predictability and sufficiency.[3] The impact of contribution obligations on affordability[4] should be addressed first by addressing the obvious and growing inequity of having

[1] *Universal Service Contribution Methodology*, WC Docket No. 06-122, Notice of Proposed Rulemaking, FCC 19-46 (rel. May 31, 2019) (*NPRM*).

[2] *See, e.g.,* Comments of NTCA—The Rural Broadband Association, at 3 ("each program of the USF, whether for high-cost areas, low-income, rural healthcare or schools and libraries, must be supported through a mechanism that is tailored to the distinct needs of that respective program.") (*NTCA Comments*); Comments of WTA—Advocates for Rural Broadband, at 9 ("each of the four separate USF programs is most effectively, efficiently and equitably administered by allowing it to focus on its own goals and to be evaluated on its own merits.").

[3] *See, e.g., NTCA Comments* at i ("An overall cap on the USF would be inconsistent with the mandate to ensure specific, predictable and sufficient support for each program.").

[4] *See NPRM* at ¶ 3 ("Our statutory obligation requires that the Commission's policies result in equitable and nondiscriminatory contributions to the [universal service] Fund . . .").

consumers of telecommunications solely bear the cost of subsidizing consumers of advanced telecommunications services (*i.e.*, broadband).[5]

Notwithstanding, CHI supports making authorized but unused Schools and Libraries (a.k.a. "E-rate") available for commitment in the Rural Health Care (RHC) Program[6] on an immediate though interim basis. CSH urges this step to ensure adequate funding is available to the RHC Program over the next several years, providing time if needed for the Commission to perform a data-driven analysis of the appropriate level of funding for that program. CSH supports maintaining E-rate applicants' priority over E-rate funds,[7] but there is no harm to E-rate if, in the near term, RHC participants access its authorized but unused funding. Indeed, maintaining such priority would avoid any impact whatsoever on the sufficiency or predictability of E-rate funding. As a longer term solution, CSH does not support the Commission's proposal for establishing a collective cap that applies to both programs. Such a collective cap is unnecessary given the individual program caps in place. Moreover, operation of a collective cap would introduce further complexity to current cap mechanics, compounding the uncertainty we have seen in the RHC program in recent years and inflicting greater uncertainty on E-rate applicants.[8]

I. BACKGROUND

CSH is a not-for-profit system of health care organizations that comprise the nation's largest Catholic health care system, serving more than twenty million people each year through operations and facilities in 21 states. CSH was formed in early 2019 by the combination of Catholic Health Initiatives (CHI) and Dignity Health (Dignity) and operates more than 700 care sites and 142 hospitals, as well as research programs, virtual care services, home health

[5] *See, .e.g.,* Comments of Smith Bagley, Inc. at 12-14 ("the Commission must begin to examine whether broadband services can be added to the contribution base, since each of the USF programs now overwhelmingly provides support to broadband."); Comments of Public Knowledge and The National Hispanic Media Coalition, at 34-35 ("While the 1996 Telecommunications Act was being debated, Senators Kerrey and McCain discussed the proposal that 'it should not be just the phone companies or should not just be the existing entities that are making a contribution to the universal service fund; that, in fact . . . these new information services should be making a contribution' in order to 'broaden the base.'") (citation omitted).

[6] *See NPRM* at ¶¶ 23-25; *id.* at ¶ 23 ("While the E-rate program has been substantially under its cap since its budget was increased to approximately $4 billion per year . . . there has been significant pressure on the Rural Health Care budget in recent years.").

[7] *See NPRM* at ¶ 25.

[8] *Cf. NTCA Comments* (anticipating that an overall cap would result in "a Rube Goldberg-type arrangement in which disparate and unrelated elements would combine to effect results that are substantively detached from various inputs."); *see also* https://en.wikipedia.org/wiki/Rube_Goldberg.

programs, and living communities.[9] CSH also supports a range of community health programs to create healthier communities and address the root causes of poor health such as access to quality care and health equity, affordable housing, safe neighborhoods, and a healthy environment.

In accordance with its mission and values, CSH commits substantial resources to sponsor a broad range of services to the poor as well as the broader community. Community benefit to the poor includes the cost of providing services to persons who cannot afford health care due to inadequate resources and/or who are uninsured or underinsured. This type of community benefit includes the costs of traditional charity care, unpaid costs of care provided to beneficiaries of Medicaid and other indigent public programs, services such as free clinics and meal programs for which a patient is not billed or for which a nominal fee has been assessed; and cash and in-kind donations of equipment, supplies or staff time volunteered on behalf of the community. Community benefit provided to the broader community includes the costs of providing services to other populations that may not qualify as poor but may need special services and support. In fiscal year 2018, CHI and Dignity had combined revenues of $29.2 billion and provided $4.2 billion in charity care, community benefit, and unreimbursed government programs.[10]

While CHI (now part of CSH) has long-recognized the critical importance of telehealth for efficiently delivering care, especially in rural areas,[11] CHI only recently began organization-wide participation in the Commission's RHC Program to help facilitate greater use of telemedicine and telehealth. CSH plans to continue to scale-up its participation in the program. CHI received $2.8 million in Healthcare Connect Fund (HCF) funding commitments in funding year (FY) 2017, and $1.3 million in FY 2018. CHI submitted funding requests for almost $9 million in funding for FY 2019 and CSH projects its funding requests will reach $25 million in FY 2020. The continued availability of RHC Program funding is critical to CSH delivering quality care to Americans in rural communities.

[9] *See* https://commonspirit.org/about-us/.

[10] *See* CommonSpirit Health™ Launches as New Health System, Press Release, Feb. 1, 2019, https://www.dignityhealth.org/about-us/press-center/press-releases/2019-02-01-commonspirit-health-launches-as-new-health-system.

[11] *See, e.g.,* Kevin E. Lofton, FACHE, CEO of CHI, *Technology is the best prescription for advancing rural care*, BECKER'S HOSPITAL REVIEW, Jun. 6, 2018, https://www.beckershospitalreview.com/hospital-management-administration/technology-is-the-best-prescription-for-advancing-rural-care.html.

II. DISCUSSION

At the outset, CSH wishes to be clear that program participants should always have priority to any USF funds authorized for their program.[12] Currently, however, E-rate demand appears to be stable with a large amount of authorized E-rate program funding unused each year. In contrast, the Rural Health Care program is growing and in recent years has been plagued by insufficiency and unpredictable cap mechanics. While the Commission has recently enacted important RHC reforms,[13] Rural Health Care program demand may continue to grow and exceed its current cap, bringing continued unpredictability and resulting financial hardships for rural health care providers like CSH. The Commission thus should establish a cap sharing mechanism that will automatically provide interim relief to the RHC program in the event program demand outpaces funding availability over the next several years. Such a step can provide certainty and predictability to the RHC program while protecting E-rate participants. Such a cap sharing mechanism – which should be a temporary fail-safe only – will provide the Commission with an important window of opportunity to consider whether growing RHC demand is in accordance with statutory objectives for the program. For example, the Commission could perform an RHC demand assessment similar to when the Commission modernized the E-rate program in 2014, establishing the current E-rate cap, and to enact further RHC reforms if warranted.

A. Allowing Rural Health Care Program Participants to Temporarily Access Authorized but Unused Funds from E-rate would not Harm E-rate Applicants.

E-rate demand has been either stable or declining for many years. Funding requests for both FY 2018 and 2019 were more than $1 billion below E-rate's allowable cap. (The current funding cap for the E-rate program for FY 2019 is $4.15 billion, up from $4.06 billion in FY 2018.[14]) Except for a slight uptick in FY 2019, demand for E-rate funding has declined every year since FY 2012 – with actual disbursements more than $1.3 billion below the cap each year.[15] The

[12] *Accord* NPRM at ¶ 25 ("To ensure that each program has a predictable level of support, we also propose that if demand for either programs were to meet or exceed their individual program funding caps, each program would continue to be subject to its individual program cap and the existing program rules would apply.").

[13] *See Promoting Telehealth in Rural America*, Report and Order, WC Docket No. 17-310, FCC 19-78 (rel. Aug. 20, 2019) (*RHC Report and Order*); *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 33 FCC Rcd 6574 (2018) (*RHC Cap Order*) (increasing the RHC cap by over $170 million and indexing it to inflation).

[14] *See Wireline Competition Bureau Announced E-rate and RHC Programs' Inflation-Based Caps for Funding Year 2019*, Public Notice, DA 19-170 (rel. Mar. 8, 2019).

[15] *See NPRM* at 11; *see also* https://www.fundsforlearning.com/blog/2019/05/fy2019-demand-shows-steady-growth. Note that demand in these statistics represent *requested* funding. E-rate and RHC programmatic funding

demand increase in 2019 (roughly $0.1 billion) appears to have only slightly exceeded the upward inflation adjustment to the cap. Moreover, the risk of a dramatic uptick in E-rate demand is probably low. Category 2 support is effectively capped because of the budget mechanism the Commission put in place in 2014 and that will likely be continued.[16] And E-rate support for voice services has been phased out. While all of the reasons that E-rate demand declined and then plateaued in recent years are not known, there is no question the E-rate program, after many years of substantial growth, has reached a degree of maturity born of its success connecting schools and libraries across the country to advanced services.[17]

In contrast, the Rural Health Care program, after many years of anemic growth, began to grow dramatically only in 2013[18] (coincidentally the same period during which E-rate demand began its decline). This increase in Rural Health Care demand coincided with changes in technology, rural economies, and federal health policies that drove increased need for, and adoption of, telemedicine and telehealth.[19] As populations aged, as the rates of chronic diseases grew, as many rural communities faced economic decline, and as rural hospitals closed – demand for Rural Health Care support increased steeply. Also, in 2016, Congress added skilled nursing facilities to the program, adding many new participating entities.[20] More recently, Medicare reimbursement codes for telemedicine have been adopted after years of consideration,[21] prompting new investments in, and adoption of, telehealth and telemedicine. There are good

caps apply to actual disbursements (*i.e.,* to support that is actually paid), not to funding requests. *See* 47 CFR §§ 54.507(a), 54.675(a).

[16] *See Modernizing the E-Rate Program for Schools and Libraries*, Notice of Proposed Rulemaking, WC Docket No. 13-184, FCC 19-58 (rel. Jul. 9, 2019) (proposing to make Category 2 budgeting permanent).

[17] *Accord, RHC Report and Order* at ¶ 129 n.384 (recognizing that the E-rate program "is further along on the development/adoption cycle than the RHC Program.").

[18] *See id.* at ¶ 7 (gross RHC funding demand more than quadrupled from $136 million in FY 2012 to $667 million in FY 2018); *RHC Cap Order*, 33 FCC Rcd at 6576, at ¶ 6.

[19] *See id.* at 6577 ("The Program's growth is largely attributable to the expansion of services and entities eligible for RHC Program support over the last five years, as well as advances in telehealth technology that require greater bandwidths. Our expectation is that Program demand will continue to grow as reliance on technology used for health care delivery increases.") (footnotes omitted).

[20] *See Rural Health Care Mechanism*, WC Docket No. 02-60, Memorandum Opinion and Order, 32 FCC Rcd 5260 (2018) ("implement[ing] the Rural Healthcare Connectivity Act of 2016, which amends section 254(h)(7)(B) of the Communications Act of 1934 (the Act), to include skilled nursing facilities (SNFs) amongst the list of health care providers eligible to receive Rural Health Care (RHC) Program support.").

[21] *See* Stephanie Zawada, *Telemedicine: The Promise and the Performance*, THE HERITAGE FOUNDATION, BACKGROUNDER NO. 3373, at 9 (2018) (*Zawada*), https://www.heritage.org/sites/default/files/2018-12/BG3373_0.pdf (accessed Aug. 21, 2019).

reasons then, that the RHC program demand may continue to grow, with such growth fully in accordance with statutory purposes for the program.

In the event E-rate funding does grow, E-rate applicants would continue to have first-rights to that funding. In no case should the Commission allow increases in Rural Health Care funding demand to cause E-rate applicants to face funding unpredictability or insufficiency. Nevertheless, it makes no sense to have $1 billion in authorized but unused E-rate funding while the Rural Health Care applicants face continued funding unpredictability or cuts.

B. Allowing Rural Health Care Program participants to Access Unused E-Rate Funds will Avoid Harmful Funding Reductions in the Rural Health Care Program Pending an Appropriate Needs Assessment

CSH recognizes the Commission has taken significant steps to improve the Rural Health Care program over the last several years: increasing available RHC funding in 2018 and adopting RHC program reforms to ensure efficient use of limited funds. Nevertheless, CSH is one of the largest rural health care providers in the nation and expects to increase its use of the program substantially over the next few years. It plans to do so for all of the reasons driving the need for RHC funding across the nation: fewer rural hospitals, growing aging populations, increasing rates of chronic illness, shifting rural economic fortunes, the need to reduce costs, and the rural chemical dependency crisis (including opioids and other substances). Indeed, CSH's experience as an exceptionally large *rural* health care provider is itself evidence that demand for Rural Health Care funding will likely continue to grow. CSH believes the Rural Health care program is becoming the program Congress envisioned in 1996 when it was conceived as a companion to E-rate. Indeed, Telehealth continues to offer tremendous promise of cost savings and increased access to care,[22] and rural America needs broadband-enabled telehealth and telemedicine more than ever. The country thus needs a robust, and possibly growing, Rural Health Care program.[23]

Notwithstanding the Commission's recent Rural Health Care program improvements and reforms, no thorough demand assessment for RHC funding has been performed since 1997. This contrasts once again with E-rate. In 2014 the Commission solicited comments from E-rate

[22] *See Zawada* at 1 ("Telemedicine, the delivery of primary and specialty medical care enabled by telecommunication devices, offers less costly, more personalized health care options than conventional in-person visits. . . . Harnessing the power of innovative technologies, telemedicine also can maintain or improve the quality of established medical services).

[23] *Id.* at 2 ("policymakers should review statutory definitions as well as reimbursement, licensure, and tax policies to better accommodate the growth of telemedicine."). In the recent RHC Order, the Commission eloquently recognized the many reasons driving demand in funding. *See RHC Report and Order,* ¶¶ 1-2.

stakeholders specifically on the question of "future funding levels for the E-rate program in order to meet the established goals [of the program]."[24] The Commission ultimately used this information to identify the "anticipated costs to meet the [program] goal of ensuring affordable access to high-speed broadband sufficient to support digital learning in schools and robust connectivity for all libraries."[25] As the recent Rural Health Care program reforms take effect, the next logical step for the Rural Health Care program is for the Commission to engage the question of what level of funding is truly needed to fulfil the statutory and policy goals for the program. The cap sharing mechanism we urge the Commission to adopt will provide the Commission the necessary time to perform such an exercise before imposing cuts in RHC funding.

III. CONCLUSION

For the reasons stated above, CSH respectfully requests that the Commission adopt a cap sharing mechanism for the E-rate and RHC programs, as a temporary measure to protect against funding shortfalls. CSH does not believe that a collective cap should be applied, however, and believes program funding levels should be set independently based on an objective, data-driven assessment of the levels of funding that are needed to achieve statutory objectives.

Respectfully submitted,

/s/

Jeffrey A. Mitchell
Counsel for CSH

Cc Gregory Jacobs, Polsinelli, PC
Counsel for CSH

[24] *See Modernizing the E-Rate Program for Schools and Libraries*, Second Report and Order and Order on Reconsideration, 29 FCC Rcd 15538, 15570, ¶ 80 (2014) (*2014 Second E-Rate Order*).

[25] *Id. at* ¶ 81.